Reset Form

APPLICATION FOR LICENSURE AS A RESIDENTIAL CARE ADMINISTRATOR

State Form 53787 (12-08)
Approved by the State Board of Accounts 2008

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2051
E-mail: pla6@pla.IN.gov
www.pla.IN.gov

FOR OFFICE USE ONLY		
Application fee	Temporary permit fee	
Date fee paid (*month, day, year*)	Date fee paid (*month, day, year*)	
Receipt number	Receipt number	
License number	Temporary permit number	
Issuance date (*month, day, year*)	Issuance date (*month, day, year*)	
State exam fee	Date fee paid (*month, day, year*)	Receipt number

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name *(last, first, middle, maiden)*			Email address
Address *(number and street or rural route)*			City, state, and ZIP code
Social Security number *	Telephone number ( )	Date of birth *(month, day, year)*	Location of birthplace

TEMPORARY PERMIT
Are you requesting a temporary permit? ☐ Yes ☐ No

YOU MUST HAVE A CURRENT LICENSE IN ANOTHER STATE TO QUALIFY FOR A TEMPORARY PERMIT.

EDUCATION REQUIREMENT

This information must be verified by official transcript or notarized copy of your diploma. The specialized course of study must be verified by certificate. Please check one:

☐ I have a **BACCALAUREATE DEGREE** or higher from an accredited institution.

☐ I have an **ASSOCIATE DEGREE** in health care **and** took the **SPECIALIZED COURSE OF STUDY** prescribed by the board.

☐ I have taken the **SPECIALIZED COURSE OF STUDY** prescribed by the board.

ADMINISTRATOR-IN-TRAINING

*Please check all that apply below if you are **NOT** applying for a full waiver of the Administrator-In-Training program:*

☐ **I am requesting approval to enter the Administrator-In-Training program.** *You must have your preceptor complete the preceptor application. The preceptor application must be approved before your health facility administrator application can be processed.*

WAIVER OF THE ADMINISTRATOR-IN-TRAINING PROGRAM

If you are applying for a waiver of the Administrator-In-Training program, please check one (1):

☐ **I have one (1) year of active work experience as a licensed residential care administrator in another state.** *This experience must be verified by your employer on the "Verification of Employment" form.* **Endorsement Candidates Only.**

☐ **I have completed a training program required for licensure as a residential care administrator in another state.** *The Indiana State Board of Health Facility Administrators must determine that this program is equivalent to the Administrator-In-Training requirements in this state. You must have the state board complete the "Verification of Administrator-In-Training Program" form.* **Endorsement Candidates Only.**

☐ **I have a master's degree in health care administration and six (6) months of active work experience as a licensed residential care administrator in another state.** *Your education must be verified by transcript or by a notarized copy of your diploma. Your experience must be verified by your employer on the "Verification of Employment" form.* **Endorsement Candidates Only.**

☐ **I have completed a residency-internship in health care administration completed as part of a degree requirement.** *The Indiana State Board of Health Facility Administrators must determine that this is equivalent to the Administrator-In-Training requirements in this state. You must submit documentation verifying the residency / internship.*

☐ **I have at least one (1) year of active work experience as a chief executive officer or chief operations officer in a hospital.** *This experience must be verified by your employer on the "Verification of Employment" form.*

(*Continued on reverse side*)

WAIVER OF THE EDUCATION REQUIREMENT AND THE ADMINISTRATOR-IN-TRAINING PROGRAM

Please check the box below if applicable: **FOR ENDORSEMENT CANDIDATES ONLY**

☐ **I have two (2) years of active work experience as a licensed residential care administrator in another state.**
This must be verified by your employer on the "Verification of Employment" form.

EXAMINATION

* All candidates for licensure in Indiana must complete the state jurisprudence examination. If your application is approved, you will receive instructions regarding preparation for the state examination. If you have completed the RCAL examination, please fill in the information below:

Previously passed RCAL exam in the state of:	Date of exam *(month, day, year)*	What was your score? (*raw or scaled*)

POST-SECONDARY EDUCATION

NAME AND LOCATION OF SCHOOL	TYPE OF DEGREE / CERTIFICATE	DATE OF COMPLETION (*month, day, year*)

List all states, including Indiana, in which you hold or have held a license, certificate, registration or permit to practice any regulated health occupation.

LICENSE TYPE	STATE	NUMBER	DATE OF ISSUE (*month, day, year*)	CURRENT STATUS

If your answer is "yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date and disposition. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to the application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a residential care administrator or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now, or have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No
4. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. To any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines.)* ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subject to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a residential care administrator or as another health care professional? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or information pertaining to the undersigned, requested by the Agency or any of its authorized representatives in connection with processing my application for licensure as a residential care administrator.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and hereby specifically release the Agency and the Board from any and all liability in connection with such disclosure. A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed *(month, day, year)*